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ABSTRACT

This report summarizes information on juvenile detention facilities using staff supervision rather than architectural barriers, such as barred windows and locked doors. Results of a survey of staff secure facilities are detailed in the appendix and eight tables of data are provided. Topics covered in the appendix, which comprises most the document, include background of staff secure programs for juveniles; objectives, scope, and methodology of the survey; characteristics of facilities visited; characteristics of juveniles placed in facilities and various reasons for their placement; and the variety of staff secure programs. Various physical restraint methods used for juveniles are discussed and safeguards used to avoid abuse are presented. Lengths of stay, costs of facilities, the disposition of juveniles leaving staff secure facilities and other treatment facilities, and the advantages and disadvantages of staff secure facilities are also examined. Major results concerning the reasons for juvenile placement, the methods used to restrain juveniles, the safeguards used to prevent juveniles from being abused, and the range of time juveniles were held in the facilities are emphasized in the initial summary. (ABB)

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GAO

Report to Congressional Requestors

December 1985

JUVENILE JUSTIC

Detention Using St
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United States
General Accounting Office
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General Government Division

B-202245

December 13, 1985

The Honorable Arlen Specter, Chairman
The Honorable Jeremiah Denton
The Honorable Howard M. Metzenbaum
Subcommittee on Juvenile Justice
Committee on the Judiciary
United States Senate

This report responds to your request of February 11, 1985, in which you asked us to obtain information about staff secure juvenile detention programs across the country. As opposed to secure detention, which uses architectural restraints such as barred windows and locked doors, the staff secure concept uses around-the-clock supervision by trained staff to detain juveniles who require some form of detention, but for whom secure detention is not appropriate. You noted that concerns have been raised that the staff secure concept is ambiguous and may lead to overzealous application by judges and excessive physical restraint by facility staff. We met with subcommittee representatives and agreed to visit staff secure juvenile facilities in several states and interview juvenile justice experts to obtain information concerning the

- reasons why juveniles were placed in the facilities,
- methods used to restrain juveniles in the facilities,
- safeguards used to prevent juveniles from being abused, and
- range of time juveniles were held in the facilities.

We briefed subcommittee staff on the results of our survey on October 16, 1985. This report summarizes the information presented at the briefing.

We discussed the staff secure concept with juvenile justice experts and visited 24 staff secure facilities in 10 states. At each facility, we interviewed the director, at least one staff member, and one juvenile resident when available; toured the facility; and obtained available statistics, policies, and regulations. Our work was conducted between March 17, 1985, and October 16, 1985, in accordance with generally accepted government auditing standards, except that, because of time constraints, we did not verify the reliability or validity of the statistics and other information provided to us.

In the juvenile justice system, juveniles are generally classified into three categories: delinquents, status offenders, and nonoffenders. Delinquents are juveniles who have either been charged with or convicted of

a criminal offense. Status offenders are youths who are accused of committing or have committed an offense which would not be an offense if committed by an adult (e.g., running away from home, truancy, or violating curfew laws). Nonoffenders are youths who are before the juvenile court because of various nondelinquent circumstances (e.g., neglected or abused children).

Currently, nothing in the Juvenile Justice and Delinquency Prevention Act of 1974, as amended (42 U.S.C. 5601), or federal regulations specifically prohibits states that receive grants under the act from keeping juvenile status offenders or nonoffenders in staff secure facilities. These juveniles, however, are not to be kept in secure facilities which include construction fixtures designed to physically restrict the juveniles' movements. The states can decide on the types of facilities and physical restraints authorized for status offenders and nonoffenders in staff secure facilities.

In the staff secure facilities we visited, we found that the reasons for placing juveniles in the facilities, the methods of physical restraint staff were allowed to use, the safeguards that were established to avoid abuse, and the amount of time juveniles were held in the facilities varied widely. Whether or not juveniles ran away from the facilities also varied widely even among those facilities that used physical restraint to prohibit runaways. The results of our survey are summarized below and discussed in detail in the appendix, as are additional details concerning our objectives, scope, and methodology.

- The 24 facilities we visited had different characteristics and purposes, but generally fell into two groups—14 custodial and 10 treatment. Based on descriptions provided by facility directors, we classified facilities as custodial if they were designed to hold juveniles to assure their appearance in court and/or to provide them with a place to stay. Facilities were classified as treatment if they were designed to facilitate change in juveniles' lifestyles through behavior modification programs such as counseling and alcohol abuse rehabilitation.
- Juveniles were referred to the facilities for various reasons and by different sources. Twelve of the 24 facilities housed juvenile delinquents, status offenders, and nonoffenders; 8 facilities housed juvenile delinquents and status offenders; 2 facilities held only delinquents; and 2 facilities held only status offenders. Juveniles were referred to the facilities by the police, courts, state agencies, parents, and the juveniles themselves. Juveniles were placed in the facilities for various reasons, such as to protect the juveniles from themselves and others, to assure

their appearances in court, and to prevent future status and delinquent offenses.

- Nineteen facilities had neither locks nor bars on any doors or windows to prevent the juveniles from leaving. Three facilities had some windows or doors that were locked or nailed shut, but they also had at least one door that was not locked. The remaining two facilities had architectural barriers, such as locks on all outside doors and security grates on some windows.
- Directors from 15 of the 24 facilities said that they did not allow any physical restraint to prevent juveniles from leaving. Instead, they used oral persuasion and other nonphysical methods. The remaining nine facility directors said they would use physical restraint to prevent juveniles from running away, to ensure the juveniles' safety and/or their appearance in court. All but one of the directors said that physical restraint of juveniles was allowed for protection purposes, such as breaking up fights, or to prevent the juveniles from harming themselves, others, or property.
- The reported rates of juveniles running away from facilities that would not use physical restraint to prevent runaways were mixed, with four facilities having runaway rates above 10 percent and six having runaway rates of 10 percent or less. The rates for facilities that would use physical restraint to prevent runaways was generally low, with two of eight facilities with rates exceeding 10 percent.
- At the facilities we visited, a variety of monitoring and inspection methods were used to ensure that juveniles were not abused by staff or other juveniles. These included requiring that the staff prepare incident reports when restraint was used, periodic monitoring of juveniles by staff, and inspections by state agencies.
- The averages and ranges of lengths of stay for the facilities we visited varied by the type and purpose of the facilities. For example, minimum and maximum stays ranged from 1/2 hour in an emergency holdover facility to 2 years in a long-term treatment facility.

As requested by subcommittee representatives, we did not obtain official agency comments on this report. However, we briefed Office of Juvenile Justice and Delinquency Prevention officials on the results of our work. We trust that the information provided will be useful in your legislative considerations concerning the staff secure concept. As arranged with the subcommittee, unless you publicly announce the contents of the report earlier, we plan no further distribution until 30 days

from the date of the report. At that time, we will send copies to interested parties and make copies available to others upon request.

W.J. Anderson

William J. Anderson
Director

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Abbreviations

OJJDP Office of Juvenile Justice and Delinquency Prevention

Staff Secure Programs for Juveniles

Background

In the juvenile justice system, juveniles are generally classified into three categories: delinquents, status offenders, and nonoffenders. Delinquents are juveniles who have either been charged with or convicted of a criminal offense. Status offenders are youths who are accused of committing or have committed an offense which, if committed by an adult, would not be an offense (e.g., running away from home, truancy, or violating curfew laws). Nonoffenders are youths who are before the juvenile court because of various nondelinquent circumstances (e.g., neglected or abused children).

The Juvenile Justice and Delinquency Prevention Act of 1974, as amended (42 U.S.C. 5601), established the Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the Department of Justice to provide federal resources, leadership, and coordination for juvenile justice and juvenile delinquency programs. The major goals and provisions of the act include assisting state and local governments in removing juveniles from jails and lockups; diverting juveniles from the traditional juvenile justice system; providing alternatives to secure detention[1] of juveniles; and improving the quality of juvenile justice in the United States.

The legislative histories of the 1974 act and its amendments show that the Congress was concerned about inappropriate juvenile detention practices in the states, as well as the possible results—suicide, rape, abuse, and the increased likelihood that children would commit criminal acts after secure detention. The act authorized OJJDP to issue regulations and to employ several methods to assist state and local governments in improving their juvenile detention practices. These methods included awarding formula grant funds, which are divided between the states on the basis of population under age 18; making discretionary grants for special emphasis programs; providing technical assistance; and disseminating information. To receive formula grants, states had to agree to use secure detention only for juvenile delinquents. Juvenile status offenders who had not violated a valid court order and nonoffenders were not to be confined in secure facilities.

On February 13, 1985, OJJDP issued proposed regulations which stated that it was appropriate under the act for states to place status offenders and nonoffenders in "staff secure" detention facilities for purposes of

[1]The act defined a "secure detention facility" as any public or private residential facility that includes construction fixtures designed to physically restrict the movements or activities of juveniles or others and which is used for the temporary placement of any juvenile who is accused of having committed an offense, any nonoffender, or any other individual accused of having committed a criminal offense.

their own safety. The proposed regulations defined "staff secure" facilities as those that did not include fixtures designed to physically restrict the movement and activities of individuals placed therein. The final regulations, issued on June 20, 1985, eliminated the term staff secure because it "apparently caused some confusion" to the people who responded to the proposed regulations. The responders commented that widely varying interpretations of staff secure could lead to abuse of juveniles held in the facilities. The regulations state that secure facilities do not include facilities where physical restriction of movement or activity is provided solely through facility staff. The regulations state that OJJDP will continue to work with individuals and organizations in the juvenile justice field to define the staff secure concept in the context of effective programs that use staff control techniques, other than construction fixtures, to physically restrict the movement and activities of facility residents.

Objectives, Scope, and Methodology

By letter dated February 11, 1985, Senators Specter, Denton, and Metzenbaum of the Senate Judiciary Committee's Subcommittee on Juvenile Justice requested that we provide them with information about the "staff secure" concept by surveying existing staff secure facilities and interviewing juvenile justice experts around the country. They were concerned about potential overuse of the concept by judges and excessive physical restraint by facility staff. The request letter defined "staff secure" as around-the-clock supervision by trained staff, rather than the use of architectural restraints.

During a subsequent meeting, subcommittee staff agreed that we would visit a number of staff secure facilities throughout the country and interview experts to obtain information on the (1) reasons juveniles are placed in the facilities, (2) methods staff are permitted to use to restrain juveniles, (3) safeguards established to avoid abuse, and (4) amount of time juveniles were held in the facilities.

To gather the information, we visited 24 facilities located in 10 states;[2] reviewed copies of pertinent legislation and regulations; interviewed 9 juvenile court judges and 2 court administrators who were located in jurisdictions where we were visiting facilities; interviewed 5 state officials in Hawaii, Michigan, Tennessee, and Washington; and interviewed 8 individuals who were referred to us by subcommittee staff and OJJDP

[2]The facilities were located in Hawaii, Massachusetts, Michigan, New York, Ohio, Pennsylvania, Tennessee, Virginia, Washington, and West Virginia.

officials as knowledgeable about the staff secure concept. In order to obtain information on the purpose, practices, and architectural barriers present at each facility, we interviewed the director and at least one staff member and one juvenile resident when available; we toured the facility; and we obtained available statistics, policies, and regulations. We selected the facilities by (1) reviewing descriptions of facilities in the United States which were prepared by the National Council on Crime and Delinquency and the National Center on Institutions and Alternatives and choosing all the ones that appeared to provide 24 hour-per-day supervision of juveniles by staff, (2) calling the administrator of each facility to determine whether they considered their facilities to be staff secure, and (3) obtaining suggestions from OJJDP officials.

Characteristics of Facilities Varied

The facilities we visited had different characteristics and purposes. Based on descriptions provided us by facility directors, we characterized the facilities into two groups—custodial and treatment. Fourteen of the facilities were primarily custodial. These facilities held juveniles to assure their appearance in court and/or to provide them with a place to stay until they could be returned home or placed in another facility. Although the custodial facilities were not treatment oriented, some provided counseling to help the juveniles resolve problems. Ten facilities were treatment oriented—designed to facilitate change in juveniles' lifestyles through behavior modification programs such as counseling and alcohol and drug abuse rehabilitation.

The 24 facilities we visited were generally small. Their capacities ranged from 2 to 32 licensed beds with 19 having 12 beds or less. The types of facilities varied as shown in table I.1.

Table I.1: Types of Facilities

Description of facility	Number of facilities
Shared space (library, YMCA, Red Cross shelter)	3
Courthouse	2
Building converted from another use	2
Police station or former jail	3
Building originally designed for group care	4
Private residence	9
Mental institution for emotionally disturbed	1
Total	**24**

Juveniles Placed in Facilities for Various Reasons

At each facility visited, we obtained available information concerning the characteristics of the juveniles in residence during the most recent calendar or fiscal year, sources of referrals, and reasons for referrals. We found that 12 of the 24 facilities housed juvenile delinquents, status offenders, and nonoffenders in the same facility, and 8 housed juvenile delinquents and status offenders. Two other facilities housed only status offenders, and two housed only delinquents. The age of juveniles housed in the facilities ranged from 8 to 19 years of age. Both male and female juveniles were housed in 17 facilities, 3 housed only females, and 4 only males.

Directors at the various facilities told us that juveniles were referred to the facilities by different sources such as parents, state agencies (police, courts, and youth service agencies), and by the juveniles themselves. Fourteen of the facilities accepted juveniles from multiple sources. The other 10 facilities only accepted juveniles referred from one specific state agency.

The facility directors also told us that juveniles were placed in the facilities for various reasons such as:

- to assure appearance in court (18),
- a lack of other alternatives (16),
- the juveniles posed a danger to themselves (14),
- to prevent future status and delinquent offenses (12), and
- to protect the juvenile from others (12).

We found that the reasons juveniles were referred to facilities generally varied somewhat between facilities located in rural and urban areas. For example, in a rural southeastern area, juveniles were referred to a facility for reasons such as driving under the influence of alcohol, public drunkenness, and unruliness in public. In a mideastern urban area, juveniles were referred for running away, drug use, and being considered unmanageable by their parents. Also, according to a state report and the director of a northwestern urban facility, juveniles in that facility, unlike those in the less urban areas of the state, tended to be the tougher, streetwise youth.

Staff Secure Programs Varied

We defined "staff secure" as facilities that are secured through around-the-clock oversight of the juveniles by qualified staff rather than architecturally secured by means such as locks or bars. We asked the facility directors whether or not their facilities met this definition. Directors for

23 of the 24 facilities stated that their facilities were staff secure as we had defined the term and one said that his probably was not. The facility that was not considered staff secure by its director was a custodial facility that housed delinquents, status offenders, and nonoffenders. Although staff were assigned around-the-clock, juveniles were free to move around the building and the immediate area outside the building without being in visual sight of staff. Juveniles were also given permission to go unsupervised to a gymnasium located on the facility grounds. The director of the facility stated that juveniles could run away if so inclined.

We toured all 24 facilities to determine whether or not architectural barriers were used to prevent the juveniles from leaving. We found that 19 did not have locks or bars on any doors or windows that would prevent the juveniles from leaving. However, 2 of the 19 facilities did have window alarms and another 1 had fire alarms on 2 of its 3 exits that would go off when opened to alert the staff that someone was leaving.

Three of the other five facilities had some windows or doors that were locked or nailed shut, but the juveniles had access to at least one door that was not locked. For example, a treatment facility for adjudicated delinquent males had architectural barriers such as Plexiglas windows that could be opened no more than 6 inches. This facility used around-the-clock staff coverage to ensure that juveniles did not leave the facility. The facility's doors were unlocked but had alarms that would go off when opened. The juveniles were required to stay within sight of staff and were accompanied by staff during outside recreation. According to the program director, the state did not consider the facility to be secure.

The two other facilities provided more architectural barriers even though their directors believed that they were staff secure. One facility had security grates on all first floor windows and the two second floor bedrooms but not on the staff's second floor office windows, a second floor bathroom window, or any third floor windows. It also had dead bolt locks on the outside door which could not be opened without keys. This facility housed only delinquents in its staff secure program but also housed status offenders and nonoffenders in the same building. The second facility had electronic locks on the doors and Plexiglas windows that could be opened no more than 6 inches. Juveniles were not allowed to leave the facility unsupervised and were locked in the house, confined to the downstairs rooms during the day, and rarely went out except for medical treatment and court appearances. Recreational outings were planned in advance by staff and were used as a reward for

good behavior. According to the director, the state did not consider this facility to be secure. We observed that the facility provided custodial care and had around-the-clock staff coverage for delinquents and status offenders.

The extent of supervision by staff varied widely at the facilities we visited. For example, at one custodial facility that housed delinquents and status offenders, the staff maintained close around-the-clock supervision of juveniles. The staff assisted in preparing meals, supervised chores done by the juveniles, and participated in activities and field trips. The juveniles were supposed to be within sight of staff at all times and had to ask permission to leave a room. Juveniles also were not allowed outside the house without being accompanied by staff. There were no extraordinary security measures taken such as mechanically locked doors, locked windows, or alarm systems. The director told us that staff would physically restrain juveniles from leaving and had, on rare occasions, used handcuffs to restrain juveniles. The extent of staff supervision was less at other facilities. For example, one facility that housed delinquents, status offenders, and nonoffenders allowed the juveniles to leave the facility unsupervised to attend school or go to work. This facility would not physically restrain juveniles from leaving but would call the police if juveniles left without authorization.

Physical Restraint Methods Used for Juveniles Varied

Twenty-three of the 24 facility directors, a judge, and 4 of the 8 knowledgeable officials that we contacted said that physical restraint of juvenile delinquents, status offenders, and nonoffenders should be allowed for protective purposes, such as breaking up fights or other related activities to prevent the juveniles from harming themselves, other persons, or property. Although formal and informal policies on whether or not physical restraint should be used to prevent juveniles from leaving the facilities varied, more facilities did not physically stop juveniles from leaving than did. The methods used for restraining juveniles also varied as did staff training in the proper use of physical restraint.

Program directors at 15 of the 24 facilities we visited stated that they did not allow any physical restraint to keep a resident from leaving. These directors said that they relied on alternative methods, such as oral persuasion, confiscating the juvenile's shoes and/or outer clothing, and increasing the level of supervision, to keep the juveniles in their programs. In this regard, four knowledgeable officials and a juvenile court judge told us that the use of physical force or restraint should not be allowed to prevent juveniles from leaving staff secure facilities

because the situation could escalate and result in abuse, accidents, and law suits.

The remaining nine facility directors said that they would use physical restraint to stop juveniles from running, to ensure the juveniles' safety, and/or to ensure their appearance in court. A juvenile court judge told us that some physical restraint should be allowed so that orders of the court could be enforced. Three of the nine facilities that would physically prevent juveniles from running away had written policies on the use of physical restraint. The policies indicated that restraint could be used in the following situations:

- When the juvenile is uncontrollable, presents a serious and evident danger to self or others, and is not responding to the verbal directions of staff to deter the physical danger.
- When the juvenile is causing serious danger or destroying property and will not stop when asked to do so.
- When the juvenile is trying to escape and refuses to stop when ordered to do so by staff.
- When the juvenile has escaped and, when located and confronted by staff, refuses to return.

In our interviews with juvenile residents, we asked if they believed that they could leave if they wanted. Of the 40 residents who responded to this question, 22 said they could have left but chose to stay for various reasons. The reasons given included: the facilities were better than their homes, they wanted to complete their treatment, and the alternative placement, e.g., secure detention, would have been less desirable. The other 18 said that they felt they had to stay in their facilities. We noted that the policy of the facility regarding the use of physical restraint to prevent a runaway apparently had little, if any, bearing on the juvenile's response. For example, at one facility that would not use physical restraint to prevent runaways, two juveniles said they could leave and two said they could not leave.

Directors at 23 of the 24 facilities told us that they had formal or informal policies that permitted the use of physical restraint for protective purposes, such as in self-defense and to prevent harm to juveniles or property. The other facility director told us that restraint was never used. However, a staff member at that facility told us that he had used restraint to take a knife away from a juvenile and to break up a fight.

We asked the directors to describe the restraint methods that staff were permitted to use to stop juveniles from running away or for protective purposes. Physical holds were permitted at 17 facilities. Seven facilities isolated the juvenile from the rest of the population in a "quiet" room or area. Three facilities also allowed staff to use handcuffs to control severe incidents (fighting, destroying property, etc.), suicidal situations, or to transport runaway juveniles back to the facility. Two facilities in one state had to be granted waivers by the state licensing agency before such restraint was allowed because the state's child care facilities generally were not allowed to use handcuffs.

Staff training in the techniques and proper use of physical restraint was either provided or required at 18 of the 24 facilities. The methods used ranged from in-house seminars/demonstrations to external courses conducted by universities, police departments, and/or organizations which specialized in such training.

Various Safeguards Used to Avoid Abuse

At the facilities we visited, there were several monitoring and inspection methods used to ensure that juveniles were not being abused by staff or other juveniles. These included: periodic monitoring of juveniles by staff, inspections by state agencies, and state laws or program policies prohibiting the use of corporal punishment.

At all of the facilities, the juveniles' activities were monitored on a 24-hour basis by facility staff although five facilities allowed staff to sleep at night provided periodic checks were conducted. We also noted that all but three of the facilities required the staff to prepare "incident reports." These reports were used to detail such incidents as:

- injury to a juvenile or staff member,
- damage to property,
- a run or an attempted run, and
- the use of physical or mechanical restraints.

All facilities were subject to regular inspections by state agencies for licensing purposes or by the state and local agencies which funded the facilities. The frequency of inspections ranged from a minimum of once a month to once every 2 years. This depended, among other things, on how long a facility had been operating.

We were also advised that case workers not directly associated with the facilities routinely visited resident juveniles and were in a position to observe or obtain information on how the juveniles were being treated.

Regarding the use of corporal punishment, all the facilities we visited prohibited such use. Although one state we visited did permit the use of spanking with the flat of the hand, both of the facilities we visited in that state elected not to use any type of corporal punishment as a disciplinary measure.

Lengths of Stay Varied

Regarding residents' lengths of stay, the facilities we visited were either long-term, short-term, or emergency holdover facilities. We classified as "long-term" any facility whose policy would allow a juvenile to stay in its program for more than 6 months. Similarly, we classified as "short-term" any facility whose policy allowed a juvenile to stay in the facility from 1 week up to 6 months. Finally, we categorized as "emergency holdover" those facilities whose policy required that a juvenile be released in less than 1 week. We noted, however, that actual practices sometimes exceeded the policies.

We found that 5 of the 10 treatment facilities were long-term and 5 were short-term. Seven of the 14 custodial facilities were short-term and 7 were emergency holdover. Table I.2 summarizes the juveniles' actual lengths of stay (ranges and averages) for the 24 facilities we visited. The information is based on the most recent available statistics from the facilities and varied as to period covered.

Table I.2: Lengths of Stay

Type of facilities		Range	Average
Treatment:	long-term	4 hours to 2 years	2.5 to 12 months
Treatment:	short-term	1 day to 10 months	9 to 64 days
Custodial:	short-term	1 hour to 8.5 months	13 to 35 days
Custodial:	emergency holdover	1/2 to 87 hours	4 to 24 hours

Program officials for 11 of the 24 facilities we visited advised us that they would extend the length of stay beyond their normal policies in those instances when additional time was needed for treatment or to arrange for a place to send the juvenile. For example, one program director advised us that extensions were granted if alternative placements were not available, the family reconciliation process required

more time, or a court date had not been set. Program officials at 12 other facilities advised us that they needed either court or state agency approval to extend a juvenile's stay. The practice at the remaining facility was to let the juveniles stay as long as needed.

Other Information Concerning the Staff Secure Concept

During our visits to facilities and discussions with knowledgeable officials, we obtained additional information, wherever possible, on the cost of operating the facilities and the dispositions of juveniles leaving the facilities.

Costs of Facilities Varied

We obtained operating budgets and sources of funds, where available, from each facility we visited for the most recent calendar or fiscal year. We obtained annual operating cost data for 8 of the 14 custodial facilities and 9 of the 10 treatment facilities. We computed the annual cost per bed for the 17 facilities that had annual operating cost data. We also computed the cost per resident day for the 11 facilities where the number of resident days was available. All 24 facility directors reported their sources of funding to us. Eight facilities received some federal funding along with state, local, or private funds, and two of these facilities received OJJDP funding.

Treatment Facilities

The cost data available for treatment facilities varied as shown in table I.3. The annual operating costs for the nine facilities where we obtained this information ranged from $114,200 to $562,600. The annual cost per bed ranged from $10,382 to $45,225 and averaged $23,074. Data was available to estimate the cost per resident day for eight treatment facilities and ranged from $37 to $143.

Table I.3: Annual Operating Costs of Treatment Facilities

Treatment facility	Number of beds	Annual operating cost	Cost per bed
A	20	$ 414,000	$20,700
B	20	562,600	28,130
C	12	224,700	18,725
D	15	299,200	19,947
E	11	114,200	10,382
F	12	542,700	45,225
G	8	131,000	16,375
H	8	202,000	25,250
I	8	140,000	17,500
Total	**114**	**$2,630,400**	**$23,074**

Custodial Facilities

As shown in table I.4, the annual operating costs for eight custodial facilities ranged from $700 to $569,200. The lowest costs were for two rural facilities which paid an attendant $5 per hour for a maximum of 24 hours only when juveniles were being held in the facilities. The annual cost per bed ranged from $233 to $40,500 and averaged $19,427. The cost per resident day at the three custodial facilities where this data was available was estimated at $50, $88, and $108.

Table I.4: Annual Operating Costs of Custodial Facilities

Custodial facility	Number of beds	Annual operating cost	Cost per bed
K	12	$ 364,400	$30,367
L	8	324,000	40,500
M	9	93,100	10,344
N	2	2,600	1,300[a]
O	3	700	233[a]
P	32	569,200	17,788
Q	13	263,900	20,300
R	12	150,000	12,500
Total	**91**	**$1,767,900**	**$19,427**

[a]Only cost is $5 per hour while juveniles are in the facility. These do not include such costs as the salaries of state and local program directors and related training costs.

Four other custodial facilities which had been operating in rural areas for about 7 months did not have annual operating costs but provided us with start-up costs. The start-up costs for these facilities ranged from

$6,000 to $34,000 and averaged about $6,800 per bed. The most expensive start-up costs were to renovate an entire building, and the least expensive were to renovate space in the back of a library.

Disposition of Juveniles Leaving Staff Secure Facilities

We also collected available information about the disposition of juveniles leaving the facilities we visited. The data collected and presented in tables I.5 and I.6 were the most recent available and included calendar year, fiscal year, and, in one case, only 1/4 of a year of statistics. The disposition data, however, do not indicate how long the juveniles remained in their placements immediately following their stay in staff secure facilities nor do they indicate whether the juveniles were successful in their new placements.

Treatment Facilities

Eight of the 10 treatment facilities provided us with the actual number of juveniles in each disposition category. The other two treatment facilities did not provide any related information. Based on the 627 reported dispositions, most juveniles either returned home, ran away from the facilities, or went to foster care as shown in table I.5. The largest percentage of reported dispositions for three of the eight facilities were juveniles who ran away. The runaway rate for all eight facilities ranged from 3 to 60 percent.

Table I.5: Disposition of Juveniles Leaving Treatment Facilities (Number/Percent[a])

	Disposition category						
Facilities	**Independent living**	**Returned home[b]**	**Foster care[c]**	**Ran away**	**Secure detention**	**Other[d]**	**Total**
A	0	28	6	1	1	3	**39**
	0%	72%	15%	3%	3%	8%	**100%**
B	0	7	7	1	2	1	**18**
	0%	39%	39%	6%	11%	6%	**100%**
C	5	6	3	10	3	1	**28**
	18%	21%	11%	36%	11%	4%	**100%**
E	12	36	32	55	9	19	**163**
	7%	22%	20%	34%	6%	12%	**100%**
F	2	10	13	62	8	9	**104**
	2%	10%	13%	60%	8%	9%	**100%**
G	0	15	18	2	2	0	**37**
	0%	41%	49%	5%	5%	0%	**100%**
H	0	94	52	35	16	13	**210**
	0%	45%	25%	17%	8%	6%	**100%**
J	0	6	0	9	0	13	**28**
	0%	21%	0%	32%	0%	46%	**100%**
Total	**19**	**202**	**131**	**175**	**41**	**59**	**627**
	3%	**32%**	**21%**	**28%**	**7%**	**9%**	**100%**

[a]Total percent may exceed 100 percent because of rounding.

[b]Includes relative's home.

[c]Includes group care.

[d]Includes such dispositions as mental health facilities, friends' homes, and armed services.

Custodial Facilities

Ten of the 14 custodial facilities provided us with information on the disposition of juveniles leaving the facilities. We were not able to determine overall percentages for the dispositional categories because some of the facilities reported percentages rather than actual numbers for each category. As shown in table I.6, the largest percentage of reported dispositions in 6 of the 10 facilities were juveniles who returned home. The percentage of juveniles who returned home in each of the nine facilities that had this data ranged from 15 percent to 90 percent. The runaway rate for 9 of the 10 facilities was 10 percent or less with a 37 percent rate in the other facility. All the other dispositions were to out-of-home placements such as independent living, foster care, drug treatment centers, and mental hospitals.

Table I.6: Disposition of Juveniles Leaving Custodial Facilities (Percent)

Facilities	Disposition category					
	Independent living	Returned home[a]	Foster care[b]	Ran away	Secure placement	Other[c]
K	5	60	20	10	0	5
L	0	24	0	0	0	76
N	[d]	[d]	[d]	0	[d]	40
O	0	39	0	0	0	62
P	0	15	41	37	5	2
Q	6	52	33	4	0	4
S	0	49	38	0	2	11
T	0	88	0	0	12	0
U	[e]	90	[e]	[e]	[e]	[e]
W	0	67	0	0	0	33

[a]Includes relative's home.

[b]Includes group care.

[c]Other includes such dispositions as drug treatment, mental hospitals, and state agencies.

[d]Estimates not available.

[e]Estimates not available. Runaway rate thought to be 10 percent or less but actual statistics not available.

We also compared the rate of juveniles running away from facilities that would use physical restraint to prevent runaways to the rate for facilities that would not use physical restraint to prevent runaways. Table I.7 indicates that the runaway rate was low for most facilities that would use physical restraint with only two of eight rates exceeding 10 percent. Table I.8 shows mixed results for facilities that would not use physical restraint. Four of the runaway rates are above 10 percent and six are 10 percent or less.

Table I.7: Facilities Where Physical Restraint Would Be Used to Prevent Runaways

Facility	Type	Runaway rate (percent)
A	Treatment	3
B	Treatment	6
F	Treatment	60[a]
J	Treatment	32
K	Custodial	10
L	Custodial	0
Q	Custodial	4
T	Custodial	0

[a]Physical restraint would only be used to prevent younger juveniles, aged 12 and under, from leaving the facility.

Table I.8: Facilities Where Physical Restraint Would Not Be Used to Prevent Runaways

Facility	Type	Runaway rate (percent)
C	Treatment	36
E	Treatment	34
G	Treatment	5
H	Treatment	17
N	Custodial	0
O	Custodial	0
P	Custodial	37
S	Custodial	0
U	Custodial	[a]
W	Custodial	0

[a]Had at least 1 or 2 runaways. Runaway rate estimated to be 10 percent or less but actual statistics not available.

Advantages and Disadvantages of Staff Secure Facilities

Officials we contacted pointed out several advantages and raised several concerns about the appropriateness of the staff secure concept for status offenders and nonoffenders. The following advantages and disadvantages were cited by one or more of the officials.

Advantages

- Staff secure facilities could protect status offenders from outside influences and from the potential harm of exposing them to delinquents in secure detention. (We noted that status offenders and delinquents were housed together in 20 of the 24 facilities we visited.)

- Staff secure facilities provide rural areas with an acceptable alternative to jail for status offenders and delinquents.
- Staff secure facilities provide safe places to get the juveniles under control, to reason with them, and to find a permanent place for them to stay.
- Staff secure facilities provide greater flexibility than secure facilities in that the level of security can vary with the child's needs.

Disadvantages

- The high cost for staff secure facilities could limit any attempt to expand their use.
- Staff secure programs only work if a sufficient number of well trained and motivated staff are available. Attracting and maintaining staff may be difficult because the positions usually offer low pay with little room for advancement.
- Communities may resent the idea of staff secure facilities because they do not want such facilities in their neighborhoods or because they prefer traditional secure facilities.
- Staff secure facilities could easily be converted to secure facilities. Constant independent monitoring would, therefore, be needed to ensure that staff secure facilities that hold status offenders and nonoffenders do not adopt characteristics and practices of secure facilities.

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